



Fiscal Agent Vendor Application

Vendor Demographics

Organization Name: _____

Contact Name: _____

Telephone Number: (_____) _____ - _____ Email: _____

Are you applying as (choose one): Agency Individual Provider

Type of application (choose one): Initial application Reinstatement

Supplemental (vendor status change or adding Employer/Client)

NOTE: If adding Employer/Client, only the following is needed: Organization Name, Employer/Client Information, licensure information for the services to be provided, dated Employer/Client signature, and dated Vendor signature.

W-9 Name (as shown on tax return): _____

W-9 Business Name (if different from W-9 name): _____

W-9 Exempt: Yes No State of WI Dept. of Financial Institutions ID No.: _____

Billing and Claims Contact Information

Check all that apply: Primary Office Mailing Address Billing Address

Tax Identification Number: _____ Tax Qualifier: EIN SSN

Billing Contact Name: _____

Telephone Number: (_____) _____ - _____ Email: _____

Fax: _____

Address: _____

City: _____ State: _____ ZIP: _____

Background Check Verification for Agencies

I certify that the Agency I represent runs background checks on all employees in accordance with the Wisconsin Caregiver Program.

Yes No Not applicable (I am an individual provider.)



Employer/Client Information

Employer/Client Name: _____

Services To Be Provided	Rate	Unit
<input type="checkbox"/> Adult Day Care	\$	per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> One Time
<input type="checkbox"/> Supportive Home Care	\$	per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> One Time
<input type="checkbox"/> Pre-Vocational Services	\$	per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> One Time
<input type="checkbox"/> Daily Living Skills Training	\$	per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> One Time
<input type="checkbox"/> Day Services	\$	per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> One Time
<input type="checkbox"/> Supportive Employment	\$	per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> One Time
<input type="checkbox"/> Consumer Education and Training	\$	per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> One Time
<input type="checkbox"/> Home Modifications	\$	per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> One Time
<input type="checkbox"/> Respite	\$	per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> One Time
<input type="checkbox"/> Outside Chore Services	\$	per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> One Time
<input type="checkbox"/> Speech, Occupation, Physical or Massage Therapy	\$	per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> One Time
<input type="checkbox"/> Home Delivered Meals	\$	per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> One Time
<input type="checkbox"/> Adaptive Aids	\$	per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> One Time
<input type="checkbox"/> Transportation	\$	per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> One Time
<input type="checkbox"/> Personal Emergency Response Services (PERS)	\$	per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> One Time
<input type="checkbox"/> Other: _____	\$	per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> One Time

Vendor Driver's License Information (if providing transportation)

Will you provide transportation services? Yes No

Name (as appears on license): _____

License Number: _____ Expiration Date: _____

Liability Insurance: _____

If you are to provide specialized transportation, by submitting this application you certify that the vehicle you will use is and will be mechanically sound; has properly functioning lighting, safety, ventilation and braking systems; and has properly inflated tires without excessive wear.

IMPORTANT: Attach copy of insurance and license.



Vendor Certifications and ID Numbers

State of Licensure/Certification	ID Number	Type	Expiration Date

Other ID Numbers:

Type of Number	ID Number	Expiration Date
Medicaid Provider Number		

IMPORTANT: List all current licenses and attach copy of current license(s). For list of service occupations that have licensing requirements, see the License Requirements List.

Employer/Client Acknowledgement and Signature

I understand that the services that I will receive are subject to Medicaid regulations and that I may not charge in excess of the amount agreed upon in this application.

Employer/Client Signature: _____ Date: _____

Vendor Acknowledgement and Signature

I understand and agree that this application will not be processed until the application is deemed complete by iLIFE. It is my responsibility to provide a complete application. I understand that the burden of producing adequate information in a timely manner and for resolving doubts is my responsibility.

I certify that the information in this document and any attached documents is true, correct and complete. I understand and agree that any misrepresentation, misstatement or omission from this application, if discovered after Vendor participation has been awarded, may lead to suspension or termination of Vendor participation.

I understand that these services are provided under Medicaid regulations and that I may not charge in excess of the amount agreed upon in this application. After services have been performed per this agreement, invoices are due to iLIFE per the iLIFE Fiscal Agent Vendor Schedule.

Vendor Signature: _____ Date: _____